Application for Blue Shield Individual and Family Health Plans

Blue Shield of California and Blue Shield of California Life & Health Insurance Company

blue california

This application is for applying for coverage directly with Blue Shield for a Blue Shield Individual and Family Plan (IFP). To enroll or modify coverage obtained through Covered California, contact Covered California directly.

APPLICATION MUST BE COMPLETED IN BLUE OR BLACK INK PRINTING IN BLOCK CAPITAL LETTERS. Please make sure you answer all questions as completely and accurately as possible **and include first month's premium** to avoid a return of the application. Submit ALL pages, 1 through 8, as your complete application including any other supporting documentation to Blue Shield Attn: I&B – Applications, P.O. Box 3008, Lodi, CA 95241-9969 or fax: (888) 386-3420. The fastest and most efficient way to submit your application is online at **bscapply.com**. Call Blue Shield at **(888) 256-3650**, or contact your agent for help filling out the application. **Boxes should be marked as follows:** ☒

(PRODUCER USE ONLY)
MARKET CODE

Reason for application: ☐ Open enrollment ☐ Special enrollment period (choose one)

By selecting a special enrollment/qualifying event, you are certifying that to the best of your knowledge, you are eligible for special enrollment.

Date qualifying event triggering special enrollment occurred:

Please explain qualifying event type for special enrollment: _____

Note: You must apply within 60 days from the qualifying event to elect coverage.

☐ New enrollment ☐ Plan transfer ☐ Add dependent(s) (choose one)

If adding a dependent to existing coverage and/or requesting a plan transfer, please provide existing subscriber's Blue Shield subscriber number: _____

Part 1 – Primary applicant information

You are eligible to apply for a Blue Shield individual and family health plan if you are: a California resident and not enrolled in Medicare coverage. The medical, dental and/or vision plan option(s) chosen for the primary applicant will apply to all individuals/dependents included on this application. Individuals who would like to enroll with a plan option that is different from that of the primary applicant must fill out a separate and unique application and submit a separate first month's dues/premium.

Applicant's Social Security Number/Tax ID number		
First name		MI
Last name		
☐ Male ☐ Female	Married: ☐ Yes ☐ No Domestic partner: ☐ Yes ☐ No	Date of birth (month/day/year)

Please tell us about yourself. How would you describe your race and/or ethnicity? These questions are optional and are only used to help ensure all members have the same access to the highest quality of care.

1. Are you of Hispanic or Latino origin?	2. If yes, please select one:	3. Which race do you identify with? (select one)	
☐ Yes ☐ No ☐ Unknown ☐ Declined	☐ Cuban ☐ Guatemalan ☐ Mexican, Mexican American, Chicano ☐ Puerto Rican ☐ Salvadoran ☐ 2 or more Ethnicities ☐ Other Hispanic, Latino, Spanish: _____	☐ American Indian or Alaska Native ☐ Asian Indian ☐ Black or African American ☐ Cambodian ☐ Chinese ☐ Filipino ☐ Guamanian or Chamorro ☐ Hmong ☐ Japanese ☐ Korean	☐ Laotian ☐ Native Hawaiian ☐ Samoan ☐ Vietnamese ☐ White ☐ 2 or more Races ☐ Other ☐ Unknown ☐ Declined

If there are applicable dependents included on your application, are all dependents listed of the same race and/or ethnicity as the primary applicant? ☐ Yes ☐ No
If you answered "No", please include the race and/or ethnicity for each of your dependents in Part 3.

Applicant's home phone	Applicant's cell phone
Applicant's business phone	Applicant's fax No.

I understand and agree that any phone number(s) I provide on this Application will be used by Blue Shield to contact me about my Blue Shield contract/policy. Subject to HIPAA, I understand that information may be provided in a pre-recorded telephone message with important information about my coverage, renewal options, and other information Blue Shield determines is relevant to my coverage. I consent to allow Blue Shield to contact me and/or any dependents covered on my contract/policy at the phone number(s) I provided, including any number I provide that connects to a cell phone.	Initial _____

Applicant's email address:

I understand and agree that the email address I provide on this Application may be used by Blue Shield to contact me about my Blue Shield contract/policy. I understand that information sent to me by email could include important information about my coverage, renewal options, and any other information Blue Shield determines is relevant to my coverage. I consent to allow Blue Shield to contact me and/or any dependents covered on my contract/policy at the email I provide on this Application.	Initial _____

If a current Blue Shield member, provide subscriber number:

Home address (**NO** P.O. Box)		Apt. No.
City	State	ZIP code
Billing address (if different from above)		Apt. No.
City	State	ZIP code
Mailing address (if different from home address)		Apt. No.
City	State	ZIP code

Primary applicant's initials _____

Part 1 – Primary applicant information (continued):

Health plan option (check one box only):
Blue Shield of California plans:

Exclusive PPO plans			**Trio HMO plans**
☐ Blue Shield Platinum 90 PPO ☐ Blue Shield Gold 80 PPO ☐ Silver 70 Off Exchange PPO	☐ Silver 1950 PPO ☐ Blue Shield Bronze 60 PPO ☐ Blue Shield Minimum Coverage PPO	**HDHP Plans** ☐ Blue Shield Bronze 60 HDHP PPO ☐ Silver 2600 HDHP PPO	☐ Blue Shield Platinum 90 Trio HMO ☐ Blue Shield Gold 80 Trio HMO ☐ Silver 70 Off Exchange Trio HMO

During Open Enrollment (OE), you are eligible for a January 1 coverage effective date if you submit your application by December 15. If you submit after December 15 but before the end of OE, you are eligible for a February 1 effective date. During a Special Enrollment Period (SEP), your effective date will depend on your Qualifying Life Event (QLE) and the date you submit your application. For specific details go to **blueshieldca.com/QEchecklist**.

Requested effective date (see Part 5(b), Item 5 for information)

Note: Summary of Benefits and Coverage (SBC) forms are available for all medical plans. These forms summarize coverage and benefits for plans in a uniform manner. Log in to **blueshieldca.com/policies** to download SBC forms for any plan(s) you have applied for.

(a) Does the primary applicant currently reside in California? ☐ Yes ☐ No If no, where does the primary applicant reside? _____

Indicate language preference: ☐ English ☐ Spanish ☐ Chinese ☐ Vietnamese ☐ Korean ☐ Other: _____

Preferred method of contact (check one): ☐ Home phone ☐ Cell phone ☐ Business phone ☐ Email ☐ Standard mail | Best time to contact: _____ ☐ AM ☐ PM

Check here if you have previously had coverage with Blue Shield. ☐
If prior coverage, indicate prior Blue Shield subscriber No., if known: _____

Are you or anyone applying for coverage currently eligible for and/or enrolled with Medicare coverage? ☐ Yes ☐ No
If yes, ☐ Eligible or ☐ Enrolled. Please identify the name(s) of the applicant(s): _____

Part 2 – Primary applicant supplemental plan choices

You may also purchase a dental plan, a vision plan, or dental + vision package, and/or life insurance to supplement your health coverage. Dental, vision, dental + vision plans, and/or life insurance are also available without medical. Dental and vision plan options will apply to all individuals/dependents included on this application.

Dental and vision plan options (select only one dental plan and/or one vision plan OR Specialty Duo):
☐ Dental HMO ☐ Dental Standard HMO ☐ Dental PPO ☐ Enhanced Dental PPO 50/1250 ☐ Enhanced Dental PPO 50/2000
☐ Enhanced Dental PPO 50/2000 Lifetime Ortho 1500 ☐ Enhanced Dental PPO 25/500 ☐ Specialty Duo℠ dental + vision package*
☐ Ultimate Vision 15/25/120* ☐ Ultimate Vision 15/25/150*

Dental HMO only – visit **blueshieldca.com** to find a dental provider or for questions call **(888) 256-3650**
Dental provider name: | Dental provider No.

Life insurance* option: Life insurance is available to applicants age 1 year or older and through the age of 64. Coverage is offered in amounts starting at $10,000 and up to $100,000. Certain conditions apply for benefit amounts of $50,000 and above. In order to purchase life coverage, a separate life insurance application must be completed. For life insurance rates and to apply for coverage, please visit our website at **blueshieldca.com/term-life**.

* Underwritten by Blue Shield of California Life & Health Insurance Company (Blue Shield Life).

Part 3(a) – Spouse/domestic partner dependent applicant information

☐ Spouse ☐ Domestic partner | Sex: ☐ Male ☐ Female | Date of birth (month/day/year)

Applicant's Social Security Number/Tax ID number

If different from that of the primary applicant, which race and/or ethnicity does this dependent identify with?

First name | MI

Last name

Is the spouse/domestic partner applicant's residence the same as the primary applicant? ☐ Yes ☐ No
If no, where does the applicant reside? (address, including ZIP code and state) _____

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Primary applicant's initials _____

Part 3(b) – Child dependent applicant information

– Dependent children must be under age 26. If more than eight child dependents are applying for coverage, please attach a supplemental page providing all information listed below, your signature, and date.

☐ Male ☐ Female	Relationship: _____(e.g., son/daughter)	Date of birth (month/day/year)
Applicant's Social Security Number/Tax ID number		
If different from that of the primary applicant, which race and/or ethnicity does this dependent identify with?		
First name		MI
Last name		
Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No If no, where does the applicant reside? (address, including ZIP code and state) _____		

Part 3(c) – Child dependent applicant information

☐ Male ☐ Female	Relationship: _____(e.g., son/daughter)	Date of birth (month/day/year)
Applicant's Social Security Number/Tax ID number		
If different from that of the primary applicant, which race and/or ethnicity does this dependent identify with?		
First name		MI
Last name		
Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No If no, where does the applicant reside? (address, including ZIP code and state) _____		

Part 3(d) – Child dependent applicant information

☐ Male ☐ Female	Relationship: _____(e.g., son/daughter)	Date of birth (month/day/year)
Applicant's Social Security Number/Tax ID number		
If different from that of the primary applicant, which race and/or ethnicity does this dependent identify with?		
First name		MI
Last name		
Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No If no, where does the applicant reside? (address, including ZIP code and state) _____		

Part 3(e) – Child dependent applicant information

☐ Male ☐ Female	Relationship: _____(e.g., son/daughter)	Date of birth (month/day/year)
Applicant's Social Security Number/Tax ID number		
If different from that of the primary applicant, which race and/or ethnicity does this dependent identify with?		
First name		MI
Last name		
Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No If no, where does the applicant reside? (address, including ZIP code and state) _____		

Part 3(f) – Child dependent applicant information

☐ Male ☐ Female	Relationship: _____(e.g., son/daughter)	Date of birth (month/day/year)
Applicant's Social Security Number/Tax ID number		
If different from that of the primary applicant, which race and/or ethnicity does this dependent identify with?		
First name		MI
Last name		
Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No If no, where does the applicant reside? (address, including ZIP code and state) _____		

Part 3(g) – Child dependent applicant information

☐ Male ☐ Female	Relationship: _____(e.g., son/daughter)	Date of birth (month/day/year)
Applicant's Social Security Number/Tax ID number		
If different from that of the primary applicant, which race and/or ethnicity does this dependent identify with?		
First name		MI
Last name		
Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No If no, where does the applicant reside? (address, including ZIP code and state) _____		

Part 3(h) – Child dependent applicant information

☐ Male ☐ Female	Relationship: _____(e.g., son/daughter)	Date of birth (month/day/year)
Applicant's Social Security Number/Tax ID number		
If different from that of the primary applicant, which race and/or ethnicity does this dependent identify with?		
First name		MI
Last name		
Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No If no, where does the applicant reside? (address, including ZIP code and state) _____		

Part 3(i) – Child dependent applicant information – If more than eight child dependents are applying for coverage, please attach a supplemental page providing all information listed below, your signature, and date. Check here if a supplemental page is attached. ☐

☐ Male ☐ Female	Relationship: _____(e.g., son/daughter)	Date of birth (month/day/year)
Applicant's Social Security Number/Tax ID number		
If different from that of the primary applicant, which race and/or ethnicity does this dependent identify with?		
First name		MI
Last name		
Is the child dependent applicant's residence the same as the primary applicant? ☐ Yes ☐ No If no, where does the applicant reside? (address, including ZIP code and state) _____		

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Part 4 – Authorization for release of information

By signing this form, you are authorizing the release of your and/or your dependents' healthcare information by a healthcare provider, insurer, insurance support organization, health plan, or your insurance agent to Blue Shield of California or Blue Shield of California Life & Health Insurance Company (collectively, Blue Shield) for the purpose of processing claims and for administering benefits under the health service agreement/policy.

Further, by signing below you are authorizing Blue Shield to disclose such healthcare information to a healthcare provider, insurer, self-insurer, insurance support organization, health plan, or your insurance agent for the purpose of investigating or evaluating any claim for benefits. The healthcare information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under the federal health information privacy laws.

You have the right to refuse to sign this authorization.

You are entitled to a copy of this authorization after you sign it.

Expiration: This authorization will remain valid: 1) for thirty (30) months from the date of this authorization for the purposes of processing your application, processing a request for reinstatement, or processing a request for a change in benefits; 2) for as long as may be necessary for processing of claims incurred during the term of coverage; and 3) for the term of coverage for all other activities under the health service agreement/policy.

Right to revoke: I understand that I may revoke this authorization at any time by giving written notice of my revocation to Blue Shield. I understand that revocation of this authorization will not affect any action Blue Shield has taken in reliance on this authorization prior to receiving my written notice of revocation.

Applicant/parent or legal guardian	Today's date
Applicant/parent or legal guardian	Today's date
Applicant's spouse/domestic partner	Today's date
Applicant age 18 or over	Today's date
Applicant age 18 or over	Today's date
Applicant age 18 or over	Today's date
Applicant age 18 or over	Today's date
Applicant age 18 or over	Today's date
Applicant age 18 or over	Today's date
Applicant age 18 or over	Today's date
Applicant age 18 or over	Today's date

Continue to Part 5 – your signature and today's date are required in that section.

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Part 5(a) – Applicant verification of accuracy

Please read the following carefully. Each applying family member age 18 and older is required to review the completed application and provide their own signature. Keep a copy of this application for your records.

I alone am responsible for the accuracy and completeness of the information provided on this application. I have personally reviewed all information provided on this application, even if I did not fill out the application myself. To the best of my knowledge and belief, all information on this application is accurate, true, and complete. If Blue Shield determines that there is fraud (by act, practice, or omission) or an intentional misrepresentation of material fact in the information on this application, I understand that coverage may be rescinded as allowed by law.

For applicants with a language preference other than English: If I indicated in Part 1 that I have a language preference other than English and have completed the English version of this application (or version other than in my language preference), I confirm that I understand the questions on this application.

Signature of applicant/parent or legal guardian	Today's date	Print name (and relationship if applicant is a minor)
Signature of applicant/parent or legal guardian	Today's date	Print name (and relationship if applicant is a minor)
Signature of applicant's spouse/domestic partner (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name

Part 5(b) – Authorizations, terms, and conditions

Please read the following terms and conditions carefully. Each applicant age 18 and older is required to review the completed application and provide their own authorization and signature. Keep a copy of this application for your records.

1. **Application for coverage**: It is important to know that Blue Shield of California or Blue Shield of California Life & Health Insurance Company (as applicable) may decline your application for coverage if you are not currently eligible. Your application must be approved by Blue Shield, and an effective date for coverage assigned, before coverage may become effective.
2. **First month's dues/premium**: Blue Shield requires first month's dues/premium at the time of application submission. Find your estimated monthly dues/premium by going to **blueshieldca.com** or contact your agent. Refer to Part 7 for payment options. Failure to submit full payment of dues/premiums will result in a return of your application. Please note that processing any payment does not constitute approval of your application with Blue Shield or Blue Shield Life. If you do not currently qualify for coverage, the dues/premium you submit with your application will not be processed. If you include a check, it will be destroyed.
3. **Past due premiums**: Blue Shield reserves the right to collect any unpaid premiums for coverage in the 12-month period preceding the effective date of new coverage before issuing new coverage.
4. **Dues/premiums**: Dues/premiums are to be paid in full by the due date. Coverage will be terminated for failure to pay dues/premiums by the end of your grace period as set forth in the health service agreement/policy and as allowed by law. You will be responsible for paying the full cost of any healthcare services. And you may not be able to apply for new coverage until the next open enrollment period.

   (Required) By checking this box ☐, I acknowledge and agree to the following Blue Shield Premium Payment Policy. I also attest that either I, or an Acceptable Third Party Payor, am making and will make all future premium payments for my Blue Shield coverage:

   The Subscriber is responsible for payment of dues/premiums to Blue Shield of California and/or Blue Shield of California Life & Health Insurance Company (Blue Shield Life). Blue Shield of California does not accept direct or indirect payments of dues/premiums from any person or entity other than the Subscriber, family members or a legal guardian, or an "Acceptable Third Party Payor." Acceptable Third Party Payors are:

- Ryan White HIV/AIDS programs under Title XXVI of the Public Health Services Act
- Indian tribes, tribal organizations or urban Indian organizations
- A lawful local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf.
- Bona fide charitable organizations and organizations related to the Subscriber (i.e., church or employer) when the following is also true: payment is guaranteed for the plan year, assistance is provided based on defined financial status criteria and health status is not considered, the organization is unaffiliated with a healthcare provider, and the organization has no financial interest in the payment of a health plan claim. Financially interested institutions/organizations include institutions/organizations that receive the majority of their funding from entities with a pecuniary interest in the payment of health insurance claims, or institutions/organizations that are subject to direct or indirect control of entities with a pecuniary interest in the payment of health insurance claims.

  Upon discovery that dues/premiums were paid directly or indirectly by a person or entity other than those listed above or the Subscriber, Blue Shield of California has the right to reject the payment and inform the Subscriber that the payment was not accepted and that the dues/premiums remain due. Processing any payment does not waive Blue Shield of California's right to reject that payment and future payments under this policy.

5. **Effective date of coverage**: If you qualify for coverage, Blue Shield will notify you of your effective date of coverage. If Blue Shield cannot honor your requested effective date, or is unable to issue coverage before your requested date, coverage will begin as soon as possible. If additional dues/premiums are owed, payment must be received before coverage becomes effective. Any charges incurred for services received prior to your effective date or after termination of coverage are not covered.

   Effective dates for a special enrollment period may be different than for an open enrollment period. These effective dates are assigned by Blue Shield and may be as early as the 1st of the month following the receipt of the special enrollment period application as required by regulation, or the date of birth in the case of a newborn. For information on special enrollment period effective dates, please contact Blue Shield.
6. **Acceptance of application**: You understand that only Blue Shield can accept your application and issue coverage for an IFP plan requested on this form. Your agent or broker cannot enroll you for coverage or change any terms or conditions of coverage.
7. **Parents/guardians**: If you are the parent or legal guardian of an applicant who is a minor, please sign on behalf of the applicant at the bottom of this Part 5. As the parent or legal guardian, you are identified as the person who may make inquiries and act on behalf of the applicant regarding this coverage (as allowed by law). In addition, you are agreeing to assume all responsibility for dues/premiums payments and for following the terms and conditions for coverage. If you are not the parent of the applicant, please attach the court documents that appoint you as the guardian of this minor. Mark one of the following boxes and identify the individual authorized to act on behalf of the minor (applicant):
   - ☐ Parent only: _____ (include name and relationship), or
   - ☐ Legal guardian only: _____ (include name and relationship), or
   - ☐ My designee _____ (include name and relationship), or
   - ☐ Qualified medical child support order designee _____ (include name and relationship).
   - ☐ Mark this box if Blue Shield is to only make changes to the contract upon written request by the person identified above.
8. **Authorization for spouse/domestic partner to make changes**: If you are an applicant whose spouse/domestic partner is also applying for coverage, please specify if you authorize your spouse/domestic partner to make changes to the contract/policy on your behalf. You may discontinue this authorization at any time by sending a written request to Blue Shield. ☐ **Yes** ☐ **No**
9. **Authorization for your agent to provide/obtain information**: Check here if you do **not** authorize your insurance agent, broker, or producer (referred to as "your agent") to access all information on this application. ☐
10. **Process to authorize Blue Shield to release personal and health information to a third party**: If you would like to authorize your spouse, domestic partner, or a third party to access your personal health information, please complete the form titled Authorization for Blue Shield to Disclose Personal & Health Information to a Third Party. To obtain this form, go to **blueshieldca.com** and click on the *Privacy* link at the bottom of the page, or call **(888) 256-3650**.
11. **Response to requested information**: You agree to cooperate with Blue Shield (or Blue Shield Life, as applicable) by providing, or by providing access to, documents and other information requested (such as court orders to provide dependent coverage, etc.) to corroborate information provided in this application for coverage. You acknowledge and agree that failure or refusal to provide these documents or the information requested may be cause to rescind or cancel your coverage.
12. **Receiving materials and communications electronically versus print:** You will receive required benefit plan and coverage-related materials and communications via email and/or the Blue Shield website **blueshieldca.com**, as applicable. Documents that are made available to you via **blueshieldca.com** are as follows:

    - Blue Shield Identification (ID) card
    - Statement of Benefits (SOB)
    - Evidence of Coverage and Health Service Agreement (EOC)/Policy
    - Summary of Benefits and Coverage (SBC)

    Obtaining a document electronically will confirm your consent to electronic delivery. You also have the right to obtain printed, mailed materials at any time and at no expense to you.
    To receive printed materials in the mail, to opt out of email communications, or if you have questions, please call **(888) 256-3650**.

I have reviewed all responses pertaining to me in this application. I have read the benefit summary, Summary of Benefits and Coverage (SBC), and the terms and conditions of coverage and authorizations set forth above. With my own signature below, I represent that the information provided in this application is complete and accurate to the best of my knowledge, and I understand and agree to the terms and conditions of coverage and the authorizations I have provided. (Important: Each adult applicant must provide their own signature.) I understand that I must inform Blue Shield if anything changes or is different from what I listed on this application before my enrollment with Blue Shield begins.

Signature of applicant/parent/legal guardian	Today's date	Print name (and your relationship if applicant is a minor)
Signature of applicant's spouse/domestic partner (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name

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Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name
Signature of family member age 18 and over (if applying)	Today's date	Print name

Important: We must receive your application within 30 days of the date it is signed, during a yearly open enrollment period or within 60 days from a special enrollment triggering event.

Part 6 – Producer information: To be completed by an authorized Blue Shield agent

1. Did you complete this application? ☐ Yes ☐ No

2. If yes, did you ask each question in this application exactly as set forth? ☐ Yes ☐ No

3. Are the answers recorded exactly as given to you? ☐ Yes ☐ No, attach explanation.

4. Do you want the health service agreement/policy sent directly to the subscriber? ☐ Yes ☐ No

Producer name (the entity/individual to whom commissions will be issued)			
Email address	☐ Update email	Producer number	
Telephone number	☐ Update phone	Fax number	☐ Update fax
Producer address			
			☐ Update address
City	State	ZIP code	
Super producer name	Super producer number		

Producer signature (required)	Today's date (required)	Print name

Producers: Please ensure each part of the application is complete. In the event of missing or incomplete information, Blue Shield may contact your applicant directly to obtain complete information.

Part 7 – Billing and payment information

Calculate estimated monthly dues/premiums

- Go to **blueshieldca.com** to get estimated dues/premiums or talk to your agent to get estimated dues/premiums.
- First month's dues/premium is required at the time of application submission.
- Blue Shield will issue final dues/premium before any effective date of coverage. If the final amount differs from the estimated dues/premium and additional amounts are owed, payment must be received before coverage will take effect.

Payment options

Your first month's dues/premium can be paid by submitting a check* or money order.

* When you provide a check as payment, you authorize Blue Shield either to use information from your check to make a one-time electronic funds transfer from your account or to process the payment as a check transaction. When we use this information from your check to make an electronic funds transfer, funds will be withdrawn from your account as soon as the date we approve your application and you will not receive your check back from your financial institution.

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Blue Shield of California

Notice Informing Individuals about Nondiscrimination and Accessibility Requirements

Discrimination is against the law

Blue Shield of California complies with applicable state laws and federal civil rights laws, and does not discriminate on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability. Blue Shield of California does not exclude people or treat them differently because of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability.

Blue Shield of California:

- Provides aids and services at no cost to people with disabilities to communicate effectively with us such as:
  - Qualified sign language interpreters
  - Written information in other formats (including large print, audio, accessible electronic formats, and other formats)
- Provides language services at no cost to people whose primary language is not English such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Blue Shield of California Civil Rights Coordinator.

If you believe that Blue Shield of California has failed to provide these services or discriminated in another way on the basis of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability, you can file a grievance with:

Blue Shield of California
Civil Rights Coordinator
P.O. Box 629007
El Dorado Hills, CA 95762-9007

Phone: (844) 831-4133 (TTY: 711)
Fax: (844) 696-6070
Email: BlueShieldCivilRightsCoordinator@blueshieldca.com

You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW.
Room 509F, HHH Building
Washington, DC 20201
(800) 368-1019; TTY: (800) 537-7697

Complaint forms are available at **www.hhs.gov/ocr/office/file/index.html**.

Notice of the Availability of Language Assistance Services
Blue Shield of California

IMPORTANT: Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For help at no cost, please call right away at the Member/Customer Service telephone number on the back of your Blue Shield ID card, or (866) 346-7198.

IMPORTANTE: ¿Puede leer esta carta? Si no, podemos hacer que alguien le ayude a leerla. También puede recibir esta carta en su idioma. Para ayuda sin cargo, por favor llame inmediatamente al teléfono de Servicios al miembro/cliente que se encuentra al reverso de su tarjeta de identificación de Blue Shield o al (866) 346-7198. (Spanish)

重要通知：您能讀懂這封信嗎？如果不能，我們可以請人幫您閱讀。這封信也可以 用您所講的語言書寫。如需免费幫助，請立即撥打登列在您的Blue Shield ID卡背面上的 會員/客戶服務部的電話，或者撥打電話 (866) 346-7198。(Chinese)

QUAN TRỌNG: Quý vị có thể đọc lá thư này không? Nếu không, chúng tôi có thể nhờ người giúp quý vị đọc thư. Quý vị cũng có thể nhận lá thư này được viết bằng ngôn ngữ của quý vị. Để được hỗ trợ miễn phí, vui lòng gọi ngay đến Ban Dịch vụ Hội viên/Khách hàng theo số ở mặt sau thẻ ID Blue Shield của quý vị hoặc theo số (866) 346-7198. (Vietnamese)

MAHALAGA: Nababasa mo ba ang sulat na ito? Kung hindi, maari kaming kumuha ng isang tao upang matulungan ka upang mabasa ito. Maari ka ring makakuha ng sulat na ito na nakasulat sa iyong wika. Para sa libreng tulong, mangyaring tumawag kaagad sa numerong telepono ng Miyembro/Customer Service sa likod ng iyong Blue Shield ID kard, o (866) 346-7198. (Tagalog)

Baa' ákohwiindzindooígí: Díí naaltsoosísh yíiníłta'go bíiníghah? Doo bíiníghahgóó éí, naaltsoos nich'į' yiidóołtahígíí ła' nihee hóló. Díí naaltsoos ałdó' t'áá Diné k'ehjí ádoolníił nínízingo bíighah. Doo bąąh ílínígó shíká' adoowoł nínízingó nihich'į' béésh bee hodíilnih dóó námboo éí díí Blue Shield bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866) 346-7198 jį' hodíilnih. (Navajo)

중요: 이 서신을 읽을 수 있으세요? 읽으실 수 경우, 도움을 드릴 수 있는 사람이 있습니다. 또한 다른 언어로 작성된 이 서신을 받으실 수도 있습니다. 무료로 도움을 받으시려면 Blue Shield ID 카드 뒷면의 회원/고객 서비스 전화번호 또는 (866) 346-7198로 지금 전환하세요. (Korean)

ԿԱՐԵՎՈՐ Է. Կարողանում ե՞ք կարդալ այս նամակը: Եթե ոչ, ապա մենք կօգնենք ձեզ: Դուք պետք է նաև կարողանաք ստանալ այս նամակը ձեր լեզվով: Ծառայությունն անվճար է: Խնդրում ենք անմիջապես զանգահարել Հաճախորդների սպասարկման բաժնի հեռախոսահամարով, որը նշված է ձեր Blue Shield ID քարտի ետևի մասում, կամ (866) 346-7198 համարով: (Armenian)

ВАЖНО: Не можете прочесть данное письмо? Мы поможем вам, если необходимо. Вы также можете получить это письмо написанное на вашем родном языке. Позвоните в Службу клиентской/членской поддержки прямо сейчас по телефону, указанному сзади идентификационной карты Blue Shield, или по телефону (866) 346-7198, и вам помогут совершенно бесплатно. (Russian)

重要：お客様は、この手紙を読むことができますか？ もし読むことができない場合、弊社が、お客様をサポートする人物を手配いたします。 また、お客様の母国語で書かれた手紙をお送りすることも可能です。 無料のサポートを希望される場合は、Blue Shield IDカードの裏面に記載されている会員/お客様サービスの電話番号、または、(866) 346-7198にお電話をおかけください。 (Japanese)

مهم: آیا می‌توانید این نامه را بخوانید؟ اگر پاسختان منفی است، می‌توانیم کسی را برای کمک به شما در اختیارتان قرار دهیم. حتی می‌توانید نسخه مکتوب این نامه را به زبان خودتان دریافت کنید. برای دریافت کمک رایگان، لطفاً بدون فوت وقت از طریق شماره تلفنی که در پشت کارت شناسی Blue Shield تان درج شده است و یا از طریق شماره تلفن 346-7198 (866) با خدمات اعضا/مشتری تماس بگیرید. (Persian)

ਮਹੱਤਵਪੂਰਨ: ਕੀ ਤੁਸੀਂ ਇਸ ਪੱਤਰ ਨੂੰ ਪੜ੍ਹ ਸਕਦੇ ਹੋ? ਜੇ ਨਹੀਂ ਤਾਂ ਇਸ ਨੂੰ ਪੜ੍ਹਨ ਵਿਚ ਮਦਦ ਲਈ ਅਸੀਂ ਕਿਸੇ ਵਿਅਕਤੀ ਦਾ ਪ੍ਰਬੰਧ ਕਰ ਸਕਦੇ ਹਾਂ। ਤੁਸੀਂ ਇਹ ਪੱਤਰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿਚ ਲਿਖਿਆ ਹੋਇਆ ਵੀ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ। ਮੁਫ਼ਤ ਵਿਚ ਮਦਦ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ ਤੁਹਾਡੇ Blue Shield ID ਕਾਰਡ ਦੇ ਪਿੱਛੇ ਦਿੱਤੇ ਮੈਂਬਰ/ਕਸਟਮਰ ਸਰਵਿਸ ਟੈਲੀਫ਼ੋਨ ਨੰਬਰ ਤੇ, ਜਾਂ (866) 346-7198 ਤੇ ਕਾੱਲ ਕਰੋ। (Punjabi)

ប្រការសំខាន់៖ តើអ្នកអាចលិខិតនេះ បានដែរឬទេ? បើមិនអាចទេ យើងអាចឲ្យគេជួយអ្នកក្នុងការអានលិខិតនេះ។ អ្នកក៏អាចទទួលបានលិខិតនេះជាភាសារបស់អ្នកផងដែរ។ សម្រាប់ជំនួយដោយឥតគិតថ្លៃ សូមហៅទូរស័ព្ទភ្លាមៗទៅកាន់លេខទូរស័ព្ទសេវាសមាជិក/អតិថិជនដែលមាននៅលើខ្នងប័ណ្ណសម្គាល់ Blue Shield របស់អ្នក ឬតាមរយៈលេខ (866) 346-7198។ (Khmer)

المهم :هل تستطيع قراءة هذا الخطاب؟ أن لم تستطع قراءته، يمكننا إحضار شخص ما ليساعدك في قراءته. قد تحتاج أيضاً إلى الحصول على هذا الخطاب مكتوباً بلغتك. للحصول على المساعدة بدون تكلفة، يرجى الاتصال الآن على رقم هاتف خدمة العملاء/أحد الأعضاء المدون على الجانب الخلفي من بطاقة الهوية Blue Shield أو على الرقم 346-7198 (866).(Arabic)

TSEEM CEEB: Koj pos tuaj yeem nyeem tau tsab ntawv no? Yog hais tias nyeem tsis tau, peb tuaj yeem nrhiav ib tug neeg los pab nyeem nws rau koj. Tej zaum koj kuj yuav tau txais muab tsab ntawv no sau ua koj hom lus. Rau kev pab txhais dawb, thov hu kiag rau tus xov tooj Kev Pab Cuam Tub Koom Xeeb/Tub Lag Luam uas nyob rau sab nraum nrob qaum ntawm koj daim npav Blue Shield ID, los yog hu rau tus xov tooj (866) 346-7198. (Hmong)

สำคัญ: คุณอ่านจดหมายฉบับนี้ได้หรือไม่ หากไม่ได้ โปรดขอความช่วยจากผู้อ่านได้ คุณอาจได้รับจดหมายฉบับนี้เป็นภาษาของคุณ หากต้องการความช่วยเหลือโดยไม่มีค่าใช้จ่าย โปรดติดต่อฝ่ายบริการลูกค้า/สมาชิกทางเบอร์โทรศัพท์ในบัตรประจำตัว Blue Shield ของคุณ หรือโทร (866) 346-7198 (Thai)

महत्वपूर्ण: क्या आप इस पत्र को पढ़ सकते हैं? यदि नहीं, तो हम इसे पढ़ने में आपकी मदद के लिए किसी व्यक्ति का प्रबंध कर सकते हैं। आप इस पत्र को अपनी भाषा में भी प्राप्त कर सकते हैं। नि:शुल्क मदद प्राप्त करने के लिए अपने Blue Shield ID कार्ड के पीछे दिए गये मेंबर/कस्टमर सर्विस टेलीफोन नंबर, या (866) 346-7198 पर कॉल करें। (Hindi)

ສິ່ງສຳຄັນ: ທ່ານສາມາດອ່ານຈົດໝາຍນີ້ໄດ້ບໍ? ຖ້າອ່ານບໍ່ໄດ້, ພວກເຮົາສາມາດໃຫ້ບາງຄົນຊ່ວຍອ່ານໃຫ້ທ່ານຟັງໄດ້. ທ່ານຍັງສາມາດຂໍໃຫ້ແປຈົດໝາຍນີ້ເປັນພາສາຂອງທ່ານໄດ້.ສຳລັບຄວາມຊ່ວຍເຫຼືອແບບບໍ່ເສຍຄ່າ, ກະລຸນາ ໂທຫາເບີໂທຂອງຝ່າຍບໍລິການສະມາຊິກ/ລູກຄ້າໃນທັນທີເບີໂທລະສັບຢູ່ດ້ານຫຼັງບັດສະມາຊິກ Blue Shield ຂອງທ່ານ, ຫຼືໂທໄປຫາເບີ(866) 346-7198. (Laotian)

Notice of the Availability of Language Assistance Services

Blue Shield of California Life & Health Insurance Company

No Cost Language Services. You can get an interpreter. You can get documents read to you and some sent to you in your language. For help, call us at the number listed on your ID card or 1-866-346-7198. For more help call the CA Dept. of Insurance at 1-800-927-4357. English

Servicios de idiomas sin costo. Puede obtener un intérprete. Le pueden leer documentos y que le envíen algunos en español. Para obtener ayuda, llámenos al número que figura en su tarjeta de identificación o al 1-866-346-7198. Para obtener más ayuda, llame al Departamento de Seguros de CA al 1-800-927-4357. Spanish

免費語言服務。您可獲得口譯員服務。可以用中文把文件唸給您聽，有些文件有中文的版本，也可以把這些文件寄給您。欲取得協助，請致電您的保險卡所列的電話號碼，或撥打 1-866-346-7198 與我們聯絡。欲取得其他協助，請致電 1-800-927-4357 與加州保險部聯絡。Chinese

Các Dịch Vụ Trợ Giúp Ngôn Ngữ Miễn Phí. Quý vị có thể được nhận dịch vụ thông dịch. Quý vị có thể được người khác đọc giúp các tài liệu và nhận một số tài liệu bằng tiếng Việt. Để được giúp đỡ, hãy gọi cho chúng tôi tại số điện thoại ghi trên thẻ hội viên của quý vị hoặc 1-866-346-7198. Để được trợ giúp thêm, xin gọi Sở Bảo Hiểm California tại số 1-800-927-4357. Vietnamese

무료 통역 서비스. 귀하는 한국어 통역 서비스를 받으실 수 있으며 한국어로 서류를 낭독해주는 서비스를 받으실 수 있습니다. 도움이 필요하신 분은 귀하의 ID 카드에 나와있는 안내 전화: 1-866-346-7198번으로 문의해 주십시오. 보다 자세한 사항을 문의하실 분은 캘리포니아 주 보험국, 안내 전화 1-800-927-4357번으로 연락해 주십시오. Korean

Walang Gastos na mga Serbisyo sa Wika. Makakakuha ka ng interpreter o tagasalin at maipababasa mo sa Tagalog ang mga dokumento. Para makakuha ng tulong, tawagan kami sa numerong nakalista sa iyong ID card o sa 1-866-346-7198. Para sa karagdagang tulong, tawagan ang CA Dept. of Insurance sa 1-800-927-4357 Tagalog

Անվճար Լեզվական Ծառայություններ: Դուք կարող եք թարգման ձեռք բերել և փաստաթղթերը ընթերցել տալ ձեզ համար հայերեն լեզվով: Օգնության համար մեզ զանգահարեք ձեր ինքնության (ID) տոմսի վրա նշված կամ 1-866-346-7198 համարով: Լրացուցիչ օգնության համար 1-800-927-4357 համարով զանգահարեք Կալիֆորնիայի Ապահովագրության Բաժանմունք: Armenian

Бесплатные услуги перевода. Вы можете воспользоваться услугами переводчика, и ваши документы прочтут для вас на русском языке. Если вам требуется помощь, звоните нам по номеру, указанному на вашей идентификационной карте, или 1-866-346-7198. Если вам требуется дополнительная помощь, звоните в Департамент страхования штата Калифорния (Department of Insurance), по телефону 1-800-927-4357. Russian

無料の言語サービス　日本語で通訳をご提供し、書類をお読みします。サービスをご希望の方は、ＩＤカード記載の番号または1-866-346-7198までお問い合わせください。更なるお問い合わせは、カリフォルニア州保険庁、1-800-927-4357までご連絡ください。Japanese

خدمات مجانی مربوط به زبان. میتوانید از خدمات یک مترجم شفاهی استفاده کنید و بگوئید مدارک به زبان فارسی برایتان خوانده شوند.برای دریافت کمک،با ما از طریق شماره تلفنی که روی کارت شناسائی شما قید شده است و یا این شماره 1-866-346-7198 تماس بگیرید.برای دریافت کمک بیشتر، به CA Dept. of Insurance(اداره بیمه کالیفرنیا) به شماره 1-800-927-4357 تلفن کنید.Persian

ਮੁਫ਼ਤ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ: ਤੁਸੀਂ ਦੁਭਾਸ਼ੀਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਹਾਸਲ ਕਰ ਸਕਦੇ ਹੋ ਅਤੇ ਦਸਤਾਵੇਜ਼ਾਂ ਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਸੁਣ ਸਕਦੇ ਹੋ। ਕੁਝ ਦਸਤਾਵੇਜ਼ ਤੁਹਾਨੂੰ ਪੰਜਾਬੀ ਵਿੱਚ ਭੇਜੇ ਜਾ ਸਕਦੇ ਹਨ। ਮਦਦ ਲਈ ਤੁਹਾਡੇ ਆਈਡੀ (ID) ਕਾਰਡ 'ਤੇ ਦਿੱਤੇ ਨੰਬਰ 'ਤੇ ਜਾਂ 1-866-346-7198 'ਤੇ ' ਸਾਨੂੰ ਫ਼ੋਨ ਕਰੋ। ਵਧੇਰੇ ਮਦਦ ਲਈ ਕੈਲੀਫ਼ੋਰਨੀਆ ਡਿਪਾਰਟਮੈਂਟ ਆਫ਼ ਇਨਸ਼ੋਰੈਂਸ ਨੂੰ 1-800-927-4357 'ਤੇ ਫ਼ੋਨ ਕਰੋ। Punjabi

សេវាកម្មភាសាឥតគិតថ្លៃ។ អ្នកអាចទទួលបានអ្នកបកប្រែភាសា និងអានឯកសារជូនអ្នកជា ភាសាខ្មែរ ។ សម្រាប់ជំនួយ សូមទូរស័ព្ទមកយើងខ្ញុំតាមលេខដែលមានបង្ហាញលើប័ណ្ណសំគាល់ខ្លួនរបស់អ្នក ឬលេខ 1-866-346-7198 ។ សម្រាប់ជំនួយបន្ថែមទៀត សូមទូរស័ព្ទទៅក្រសួងធានារ៉ាប់រងរដ្ឋកាលីហ្វ័រញ៉ា តាមលេខ 1-800-927-4357 Khmer

خدمات ترجمة بدون تكلفة. يمكنك الحصول علي مترجم و قراءة الوثائق لك باللغة العربية. للحصول علي المساعدة، اتصل بنا علي الرقم المبين علي بطاقة عضويتك أو علي الرقم 1-866-346-7198. للحصول علي المزيد من المعلومات، اتصل بإدارة التأمين لولاية كاليفورنيا علي الرقم 1-800-927-4357. Arabic

Cov Kev Pab Txhais Lus Tsis Them Nqi. Koj yuav thov tau kom muaj neeg los txhais lus rau koj thiab kom neeg nyeem cov ntawv ua lus Hmoob. Yog xav tau kev pab, hu rau peb ntawm tus xov tooj nyob hauv koj daim yuaj ID los sis 1-866-346-7198. Yog xav tau kev pab ntxiv hu rau CA lub Caj Meem Fai Muab Kev Tuav Pov Hwm ntawm 1-800-927-4357 Hmong

บริการทางภาษาอย่างไม่เสียค่าใช้จ่าย คุณสามารถรับบริการจากล่าม รวมถึงให้เจ้าหน้าที่อ่านเอกสารให้คุณฟัง หรือส่งเอกสารบางส่วนในภาษาของคุณไปหาคุณได้ หากต้องการความช่วยเหลือ กรุณาโทรศัพท์ตามหมายเลขที่ระบุอยู่ด้านหลังบัตรประจำตัวของคุณ หรือ ที่หมายเลข 1-866-346-7198 หากต้องการความช่วยเหลือเพิ่มเติม โปรดโทรมาที่ กรมการประกันภัยแห่งมลรัฐแคลิฟอร์เนียที่หมายเลข 1-800-927-4357 Thai

निःशुल्क भाषा सेवाएँ। आप एक दुभाषिया की सेवा प्राप्त कर सकते हैं। आप दस्तावेजों को पढ़वा के सुन सकते हैं और कुछ को अपनी भाषा में स्वयं को भिजवा सकते हैं। सहायता के लिए, अपने ID कार्ड पर दिए गए नंबर पर, या 1-866-346-7198 पर हमें फ़ोन करें। अधिक सहायता के लिए कैलीफोर्निया बीमा विभाग (CA Dept. of Insurance) को 1-800-927-4357 पर फ़ोन करें। Hindi

Doo bááh ílínígó saad bee yát'i' bee aná'áwo'. Díí shá ata'halne'dooígí hóló̱o̱doo nínízingo éí bíighah. Naaltsoos naanin——áhájeehígí shich'į' yíidooltah éí doodagó ła' shich'į' ádoolníił nínízingo bíighah. Shíká a'doowoł nínízingo nihich'į' béésh bee hodíilnih dóó námboo éí díí ninaaltsoos dootł'ízhígí bee néího'dílzinígí bine'déé' bikáá' éí doodagó éí (866)346-7198jį' hodíilnih. Hózhó shíká anáá'doowoł nínízingo éí díí béeso ách'a̱a̱h naa'nil bił haz'á̱a̱jį' 1-800-927-4357jį' hodíilnih. Navajo

ບໍລິການແປພາສາໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍເອົາຜູ້ແປພາສາໄດ້. ທ່ານສາມາດຂໍໃຫ້ອ່ານເອກະສານໃຫ້ທ່ານຟັງ ແລະ ສົ່ງເອກະສານບາງຢ່າງທີ່ເປັນພາສາຂອງທ່ານ. ສໍາລັບຄວາມຊ່ວຍເຫຼືອ, ໃຫ້ໂທຫາພວກເຮົາຕາມເບີໂທລະສັບທີ່ມີໃນບັດປະຈໍາຕົວຂອງທ່ານ ຫຼື ໂທຫາເບີ1-866-346-7198. ສໍາລັບຄວາມຊ່ວຍເຫຼືອເພີ່ມເຕີມໂທຫາ ພະແນກ ປະກັນໄພຂອງ ລັດຄາລິຟໍເນຍໄດ້ທີ່ເບີ1-800-927-4357. Laotian